

Michigan Chapter, Docs 4 Patient Care Testimony

Health Policy Committee-Gail Haines Chairperson

State House of Representatives

January 19th 9am Thursday

Discussion on Insurance Exchanges.

On November 10, 2011, one year after an election where many of our lawmakers campaigned on a promise to protect Michigan from federal overreach of the Patient Protection and Affordable Care Act, the Michigan Senate passed SB693, establishing a PPACA-compliant health insurance exchange in Michigan and then appropriating \$9.8 million in federal funding towards this experiment. This bill was passed in a rushed and confusing manner, surprisingly reminiscent of the passage of the PPACA in March 2010.

One co-sponsor, Patrick Colbeck, wisely removed his name from the bill right before passage, voicing his opposition to the legislation. Some Senators voted against SB693, but inexplicably turned around and voted to accept \$9.8 million in federal funding to establish exchanges. Most baffling, after passing SB693, the Senators passed Senate Resolution 95 declaring the PPACA unconstitutional, basically announcing they had just violated their oaths by passing an unconstitutional bill establishing exchanges in Michigan. Communication and talking points from various exchange-supporting lawmakers show confusion and misinformation on what exchanges mean for Michigan and how little control Michigan will have in this scheme. Thankfully, the Michigan House is showing prudence on this issue with bipartisan interest in getting informed.

As practicing physicians and health care professionals focused on true health care reform that maintains the doctor-patient relationship, we strongly oppose the PPACA and by extension, its cornerstone entry into the states by insurance exchanges. Second only to the individual mandate, insurance exchanges are a crucial part of the PPACA. In fact, exchanges will be used to enforce the individual mandate. As such, it is impossible to untangle support for insurance exchanges from support for the PPACA. In discussing the issue of exchanges with many lawmakers, we have identified three main points of confusion that we must clearly address so that the House may be fully informed.

The first false argument is that a Michigan exchange will somehow differ from a federal exchange, and creating our own exchange will allow us some local control. Clearly, acceptance of \$9.8 million in strings-attached federal funding will sacrifice any local control. But even without funding, the law passed by the Michigan Senate makes no effort at local control. Conversely, the law clearly binds Michigan to the federal mandates. SB693 can be distilled down to one important sentence:

The Marketplace shall do all of the following:

"Perform all duties and obligations of an exchange required by the federal Patient Protection and Affordable Care Act."

This astounding abdication to the federal government merely supports what HHS has made clear: states may set up an exchange and call it whatever they want, but it will in no way exempt them from federal control. HHS documentation states:

Each State electing to establish an Exchange must adopt the Federal standards contained in this law and in this proposed rule, or have in effect a State law or regulation that implements these Federal standards. Section 1311(k) further specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary.”

<http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>

The first set of standards that a Michigan exchange much comply with was released this past summer--244 pages with a 103 page supplement. “Require” appears 811 times and “Must” shows up 580 times with such far reaching federal ability to set coverage, control price, and determine which doctors and hospitals may participate based on their compliance with federally defined performance regulations. Leeway and waivers from these standards are unlikely. Michigan was recently refused a waiver, and neighbor Mitch Daniels in Indiana was refused a waiver to continue the state’s highly successful Medicaid reforms.

A second concern is that the federal government will take over our insurance market and establish “one-size-fits-all” federal exchanges if the state fails to act. We’ve already established the fact that there will be one type of exchange, with all states complying with the same federal regulations, regardless of a “US” or “MI” prefix. As such, the state has nothing to lose by putting the risk and responsibility for implementation onto the federal government. We contend that these threats from the federal government are merely a bluff that we should call. Neither the political will, nor funding are available for federal implementation of exchanges and have them operational on time.

In addition, the pressure put on states to establish exchanges is likely tied to a little-publicized ‘glitch’ in the rushed and poorly-read PPACA. Insurance products on the exchanges will be expensive due to cost-inflating mandates on participating insurers. This expense will be hidden from the consumer by generous federal subsidies to purchase insurance on the exchange. The ‘glitch’ comes where the law clearly stipulates that these federal subsidies can only be used in state exchanges, not in federal exchanges. Without federal cash, consumers simply won’t patronize federal exchanges, especially when the insurance products on the exchanges will be very expensive. Federal pressure on states to establish exchanges is a simple way to cover up for a massive failure in a poorly written law.

The third argument, is that exchanges are a good idea anyway, independent of PPACA, and Michigan should establish them regardless. Some supporters go so far as to describe PPACA exchanges as “free-market”, “conservative” or “Heritage Exchanges”. Given the fact that the concept of exchanges has been around for a decade, it is disingenuous to assert Michigan has a sudden interest in exchanges, unrelated to the PPACA mandate. But even so, we can have this discussion. In medicine, we practice based on evidence. With exchanges being imposed on every state, surely there must be evidence for their success. Unfortunately, the answer is no. This is an expensive and risky experiment. Massachusetts and Utah are the only states with exchanges. We

can safely assume that Massachusetts is not an experiment we want to replicate in Michigan, so a look at Utah shows failure as well. Not only will the Utah exchange not qualify as a PPACA exchange, its history is one of failure with dismal participation and more expensive insurance products in the exchange than out. Given data that 30-50% of employers will drop health coverage under PPACA, shunting employees into the exchange bureaucracy, insurance exchanges are a grand experiment that will involve many Michiganders who believed the false claim that they would be able to keep their health insurance. Overwhelming opposition to this legislation shows that Michiganders have not given their informed consent to experimentation with their personal health insurance by a new and untested bureaucracy.

An additional point is that Michigan is a part of the 26 state and NFIB challenge to the PPACA currently pending before the Supreme Court. Any action to accept federal monies or develop an exchange undermines the efforts of Attorney General Bill Schuette and is detrimental to the merits of this multi-state case. Attorney General Schuette has made it clear that Michigan should wait on exchanges until after the presidential election, but at a minimum, should wait until after Michigan participates in the Supreme Court case. We support his opinion and efforts in this lawsuit.

The doctors and health care professionals of Docs 4 Patient Care are dedicated to preservation of the doctor-patient relationship. Our primary concern is the health and well-being of our patients. An additional concern, by extension, is the health and well-being of our state and country--physically and fiscally. The Patient Protection and Affordable Care Act neither protects patients, nor does it lead to affordable care. Rather than addressing the two fundamental problems of increased cost--lack of true competition in the insurance industry and isolation of physicians and patients from the true costs of health care--the PPACA aggravates them by limiting choices of insurance, increasing regulation and centralizing decision making.

Insurance exchanges are a vehicle by which the most disastrous federal provisions will reach the states. The majority of Americans, particularly doctors, recognize this and oppose any further implementation of this health care law. If the Michigan legislature continues on this path towards a PPACA-compliant exchange, they will deservedly receive a share of the blame and the citizens' anger for the harm this misguided legislation will cause.

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WHAT IS DOCS 4 PATIENT CARE

Docs 4 Patient Care (D4PC, www.docs4patientcare.org) is a national physician advocacy group which was launched in the spring of 2009 in Atlanta, Georgia, by Hal C. Scherz MD of Georgia Urology.

Originally conceived to oppose the passage of the Affordable Care Act, the doctor members of D4PC dedicated their efforts toward educating their patients and the public about the dangers of government-controlled health care and the destruction of the doctor-patient relationship. In a short period of time, hundreds of doctors joined with us and it became clear that D4PC needed to be more than a single issue organization.

Docs 4 Patient Care believes that there is a lack of representation and true leadership for the more than 900,000 doctors in America, most of whom are engaged daily in patient care.

Groups like the AMA claim to be the true voice of doctors, but have proven that they are more interested in protecting their organizational self interest than watching out for American health care. They had a chance to stop the Affordable Care Act from passing but instead chose to preserve their income stream by supporting this act at the expense of America's patients and the doctors that take care of them.

Docs 4 Patient Care is dedicated to:

- becoming the true voice for doctors in America
- preserving the doctor-patient relationship
- looking out for the best interests of all of our patients, not just some of them.
- working towards overturning the ACA and participating in the development of reasonable alternatives

Docs 4 Patient Care is registered with the IRS as a 501c6 corporation. It is a membership organization which MDs and DOs may join. We have an auxiliary, the Docs 4 Patient Care Alliance, which is a support group for the parent organization. People of every walk of life, including other health care professionals are encouraged to contribute to Docs 4 Patient Care through the Alliance and sign up for internet newsletters to stay informed about health care matters.

Docs 4 Patient Care has partnered with policy experts, legislators, and media to create a narrative designed to accomplish our stated goals.

Our members have appeared on over 250 syndicated radio shows and cable and network TV shows to deliver our message.

We have authored dozens of opinion pieces which have appeared in prestigious newspapers such as the *Wall Street Journal* and the *Washington Times*, and online on sites such as *Fox News*, *Human Events*, *Real Clear Politics*, and *American Thinker*.

Docs 4 Patient Care is the only doctor group asked to file an amicus brief in support of the 26 state lawsuit against the federal government over the individual mandate, currently on track to be heard before the US Supreme Court in 2012.

The President and Founder of D4PC, Hal Scherz MD, was awarded the prestigious Salvatori Award in 2011 by the Heritage Foundation for citizenship in recognition of his establishment of Docs 4 Patient Care.

We have already established chapters in many states and our intent is to have a chapter in all 50 states. The purpose of state chapters is to assist national, state, and local elected officials in health care matters, to be instrumental in the electoral process at all levels, and to educate our colleagues and the public.

Our website is already recognized as one of the premier sites for reliable health care information and is a trusted resource for health care legislative aides on Capitol Hill. The state chapters are also instrumental in the electoral process.

The list of our strategic partners is impressive and includes the Heritage Foundation, the Galen Institute, the Pacific Research Institute, Defend Your Health, the Center for Health Transformation, the Benjamin Rush Society, and the Steamboat Institute.

Most importantly, we are doctors who take care of patients every day and want to continue to do so without the government in the examination room. The organization is funded entirely by the money that we raise through membership. Our leaders have devoted hundreds and thousands of hours in developing this organization, without any financial remuneration. In fact, they have donated thousands of dollars of their own money to develop and support Docs 4 Patient Care.

Docs 4 Patient Care is a non-partisan organization. Our platform is based on free market principles and personal responsibility, putting the patient in charge of their own health care decisions and getting third parties out of the delivery of and payment for health care services. We support political candidates who espouse these positions. But as doctors, we are always keeping the patients' interests in mind, never forget that we don't take care of Democrats or Republicans; we take care of patients.



Good for Patients, Good for America

The Patient Protection and Affordable Care Act (aka ObamaCare) neither protects patients, nor does it lead to affordable care. The two fundamental problems that drive up the cost of health care in the United States are the lack of true competition in the health insurance industry and the isolation of physicians and patients from the true costs of health care. Rather than addressing these problems, ObamaCare aggravates them by limiting choices of insurance, increasing regulation, and centralizing decision making. It is the wrong prescription for health care reform in America. A majority of Americans, particularly physicians, recognize this and thus oppose the new health care law and support its repeal.

Docs 4 Patient Care is an organization of physicians dedicated to the preservation of the doctor-patient relationship. What follows is our prescription for health care reform in the United States. Our primary concern is the health and well-being of our patients. An additional concern is the health and well-being of our country –physically and financially. Accompanying each of the following eight recommendations is a rationale. These recommendations are intended to serve as a framework on which responsible legislation can be constructed.

1. Increase competition by allowing individuals to purchase health insurance across state lines.

In state capitols across the country, powerful lobbying groups have successfully added various mandates to legally allowed health insurance policies in each state. There are several thousand such mandates, averaging 45 per state. Each mandate adds to the cost of the health insurance coverage, and collectively they dramatically increase the cost of coverage. These mandated regulations are enforced by insurance regulators in each state, and the interstate sale of health insurance is prohibited.

A national competitive health insurance market must be established. In a national free market, insurance providers would list the coverage provided and the associated cost. Individuals and families can and should choose the specific coverage they need, rather than be compelled to purchase coverage that they do not find desirable or necessary. They should be able to obtain insurance coverage from any provider in any state. Market forces would eliminate providers who provide poor service, just as it does in other sectors of the economy.

2. Equalize the tax treatment of money spent for health insurance by employers and individuals.

The most significant expansion of employer-sponsored health insurance plans occurred in response to wage controls imposed by the government during World War II. The War Labor Board declared that fringe benefits, such as health insurance, did not count as wages. Employers responded by offering health insurance

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as a benefit to attract higher quality employees. The marriage between employment and health insurance was further cemented in 1954 when the Internal Revenue Service decreed that premiums paid by employers for employee health insurance were exempt from income taxation. These conditions result in an unnecessary union between employer and health insurance coverage, and they encourage employees to demand, and thus employers to provide, much more expensive coverage than individuals would otherwise purchase themselves. This drives up the cost of insurance coverage. Furthermore, these conditions are unfair to the self-employed, who do not receive the same tax benefits.

Private ownership of health insurance policies would make health insurance portable and more affordable, and would make tax treatment of health insurance premiums more equitable. If employers need to attract better employees, they should offer higher wages.

3. Encourage the Health Savings Account qualified High Deductible Health Plan (HSA qualified HDHP) model as the basic structural health insurance model across the entire spectrum of health insurance options by broadening allowable use.

The purpose of insurance is for the protection from asset loss as a result of unpredictable, uncontrollable occurrences. The evolution of employer-sponsored health plans during World War II, followed by the provision that health insurance was subject to collective bargaining eventually led to a departure from the original purpose of health insurance to the notion that health insurance would cover any and all health-related expenditures. When health care consumers are insulated from the actual cost of care, they tend to over-utilize services, ultimately leading to the rapid escalation of health care costs.

By broadening their allowable use, HSA qualified HDHP's will become a preferred choice of health plan. By putting the decision-making control and responsibility for basic health care costs back into the hands of the consumer (the patient), HSA qualified HDHP's will make the patient a better and wiser consumer of health care, will control costs, and will ultimately lead to improved quality of care through increased competition.

4. Promote transparency in medical costs.

In order to be informed consumers, the cost of health care services must be made readily available to patients prior to the time of service. This includes doctors, hospitals, pharmacies and outpatient facilities. These costs should be readily available to health care consumers on the internet, and in providers' facilities.

5. Encourage medical liability reform.

ObamaCare does nothing to substantially address the medical malpractice crisis, and, in fact, it punishes states that already have tort reform in place by excluding them from grants to study the issue. Meanwhile, the malpractice crisis continues. Frivolous law suits and resultant defensive medical practices cost the consumer billions of dollars every year. A recent study by the Cato Institute notes that in 2002, the medical liability system provided benefits of \$30.0 billion, but cost \$113.7 billion, imposing a cost on society of \$80.7 billion, to say nothing of the additional hidden costs of defensive medicine. The Congressional Budget Office estimates (some might argue very conservatively) that tort reform similar to that which already exists in some states would reduce the federal deficit by \$54 billion over the next 10 years.

No national prescription for health care reform should be without medical liability reform as a prominent component. The solution to this problem must respect each state's right to address this problem at the state level. However, given that the liability crisis increases the cost of medical care, we recommend that the federal government incentivize states to have meaningful tort reform in place by increasing federal health care-related subsidies to the states that have meaningful reform enacted. Components of meaningful tort reform could include several or all of the following:

1. A cap on awards for non-economic damages of \$250,000.

2. A cap on awards for punitive damages of \$500,000 or two times the award for economic damages, whichever is greater.
3. Modifications of the "collateral source" rule to allow evidence of income from other sources to be introduced at trials or to require that such income be subtracted from jury awards.
4. A statute of limitations – one year for adults and three years for children from the date of discovery of an injury.
5. A fair share rule, under which a defendant would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.
6. Specialty panels to determine if claims are potentially meritorious.
7. Specialty courts to hear meritorious claims and award damages.
8. Loser pays legal fees.
9. No-fault insurance.

6. Transform Medicare into a defined contribution program.

When Medicare was introduced in 1965, the federal government became a de facto health insurance provider for its senior citizens. By taking on a role that it is unqualified to fulfill, it has taken on costs which are far above those that were originally projected. These costs are bankrupting our country. Furthermore, the federal government establishes reimbursement rates for health care providers under Medicare, and the private health insurance industry establishes reimbursements based on these rates. This artificial price fixing does not allow free market forces to work within the health care system and results in an upward pressure on health care costs.

The United States should honor its commitment to provide health care coverage to its seniors. However, with \$38 trillion in unfunded obligations and projections from the Medicare trustees of bankruptcy by 2018, the current Medicare program is unsustainable. ObamaCare only aggravates these circumstances by withdrawing more than \$500 billion from Medicare (which are then used to fund new entitlements under ObamaCare). Those cost "savings" will come largely from decreased reimbursement to health care providers, which will lead to an increasing number of providers who are unwilling to treat Medicare patients and will opt out of the program. Our senior citizens deserve better.

We support the creation of a new Medicare program for future retirees in which the federal government provides a payment to assist individuals to purchase and maintain health insurance. Payments to individuals would be adjusted by income level, inflation and other appropriate factors. Participating health insurance providers would be required to provide insurance to all comers, thus assuring that all patients will be covered. In this fashion, patients would be empowered to choose the health coverage that best suits their needs, rather than being provided with a one-size-fits-all program.

Until Medicare as we know it is phased out and the transition to private health insurance is accomplished, physician compensation under Medicare part B will continue to be problematic. In 1998, the sustainable growth rate (SGR) formula for physician reimbursement was established. The SGR was based on GDP, which over time has risen more slowly than actual health care practice costs. As a result, physician reimbursements under Medicare have fallen behind costs, making it untenable for many physicians to continue to see Medicare patients. We recommend that the SGR be abandoned. In its place, we recommend that Medicare standardize reimbursements to physicians, eliminate geographical variations in reimbursements, and allow physicians to bill Medicare patients for the balance of the cost of care not covered by Medicare.

7. Restructure Medicaid to assist low-income families to purchase health insurance.

Under ObamaCare, an additional 18 million Americans will be "insured" by simply increasing the eligibility for the Medicaid program, thus placing them on Medicaid. However, the inherent flaws in Medicaid were not addressed. Physicians nationwide are refusing to see Medicaid patients due to payment levels from the Medicaid program that

are insufficient to cover the physician's cost to provide the service. This results in difficulty for Medicaid recipients to locate providers willing to accept Medicaid. Medicaid is a leading item on most states' budgets. States, already facing serious budget deficits, are unable to absorb the additional Medicaid expenditures resulting from the dramatic expansion of the Medicaid roles. Medicaid as it now exists is a disaster for physicians, patients and states alike.

We support the elimination of Medicaid as it now exists. We support the proposal to remove the federal share of Medicaid payments to the states, and to replace it with allotments to the states determined by the state's per capita low-income population. The states should not function as health insurance providers, but should be encouraged to investigate other private options for providing health care to low-income citizens. We encourage states to subsidize low-income citizens based on their income to allow them to purchase private health insurance, and individuals should be strongly incentivized to purchase HSA/HDHPs. This approach would accomplish the following:

1. Save the states money by extricating them from being health insurance providers.
2. Increase availability of providers.
3. Improve reimbursement for health care providers.
4. Increase quality of care.
5. Incentivize patients to be prudent health care consumers.

8. Encourage pooling.

States should be encouraged to set up mechanisms such as high-risk pools that allow individuals with pre-existing conditions to obtain health insurance with state assistance. Protections for those with preexisting conditions who maintain continuous coverage should be extended in order to reward responsible behavior and minimize the number of patients requiring high-risk pools in the future.

Group purchasing arrangements based on membership in organizations such as professional and small business associations and religious groups should be promoted. Participation in these groups should be allowed across state lines.

Summary

The recently passed ObamaCare takes the control of health care decisions out of the hands of patients and places it into a dramatically expanded federal bureaucracy. This top-down, centralized control of health care has everything to do with power, but nothing to do with health care.

We believe in the capacity of our patients to make the right decisions, and we support the rights of our patients to make their own health care decisions. That is why we oppose ObamaCare and support its repeal.

The physicians at Docs 4 Patient Care present a prescription for health care reform that addresses the root causes of the problems that have developed in our health care system over the last 50 years. These reforms relieve the federal government of its role as a health insurance provider, prevent the intrusion of the government in the health care free market, and place patients in control of their own health care decisions.

ObamaCare is the wrong prescription for health care reform. Let's get it right this time.



Appendix 1

Rejecting health-care exchanges

BY SALLY C. PIPES AND DR. HAL SCHERZ Post and Courier, December 29, 2011
<http://www.postandcourier.com/news/2011/dec/29/29pipes/>

The Internal Revenue Service recently held a hearing that could have major ramifications for Obamacare's much-ballyhooed insurance exchanges. The agency is trying to change the way the federal government hands out subsidies through the exchanges. There's one problem, though -- the IRS doesn't have the power to rewrite the law. The uncertainty surrounding the exchanges offers state governments a tremendous opportunity to halt Obamacare's implementation. By refusing to establish exchanges, state leaders can force Congress to revisit the disastrous law - and replace it with reforms that will actually improve the accessibility and affordability of health insurance.

Obamacare instructs states to set up health insurance exchanges where consumers and small businesses can look for coverage starting in 2014. The exchanges would effectively put health insurance -- and the delivery of care -- under the control of the feds, who would dictate what policies would look like and how doctors would treat patients with exchange-provided coverage. The feds have further stipulated that people can only access billions of dollars in tax credits and subsidies earmarked for the purchase of policies by shopping in the state-run marketplaces. If a state refuses to set up its own exchange, Obamacare allows the federal government to come into the state and set one up.

But here's the rub. The text of the law stipulates that only state-based exchanges -- not federally run ones -- may distribute credits and subsidies. Without the federal cash, consumers won't patronize the government-run exchanges -- particularly with all the cost-inflating mandates they impose on insurers who wish to participate. The Obama administration has said that Congress didn't mean to draw a bright line between federal and state-chartered exchanges. But it's not the president's job to determine congressional intent -- that's up to the legislative branch and the courts.

A major legal battle is doubtless on the horizon. In the meantime, state officials should force the federal government's hand by daring them to set up exchanges they're not empowered to fund. In many states, that's happening. To date, only 17 states have passed the necessary legislation to establish their own exchanges. Florida Gov. Rick Scott sent back a \$1-million federal exchange grant, as did Louisiana Gov. Bobby Jindal. Asked about the decision, Scott, a former health-care executive, was blunt: "I don't believe in the exchange. It doesn't do anything to improve access to care. It does nothing to drive down health-care costs."

Scott and Jindal are right to be concerned. Obamacare's other insurance regulations are forcing private insurers to pull out of certain states, where they're facing huge potential losses thanks to the law. Obamacare's defenders claim that the exchanges will expand consumer choice. With insurers exiting state markets across the country, the opposite appears to be true. In fact, the exchanges may represent the first stages in the death of private insurance.

If Obamacare's exchanges and other rules prevent private firms from making money writing health-care policies, they'll get out of the business. At that point, the government may feel justified in setting up its own plan to fill the void -- and the march toward government-run, single-payer health care will be under way.

The Obama administration and congressional Democrats may be kicking themselves over the errors they're discovering in their signature law. But for state officials -- and American patients -- anything that arrests the implementation of Obamacare is a blessing in disguise.

Sally C. Pipes is president, CEO, and Taube Fellow in Health Care Studies at the Pacific Research Institute. Hal Scherz, M.D., is a urologist in Atlanta, and Founder and President of Docs4PatientCare.Org.

Appendix 2

Obama Administration Denies Waiver for Indiana's Popular Medicaid Program

By AVIK ROY, Forbes Magazine 11/11/2011

<http://www.forbes.com/sites/aroy/2011/11/11/obama-administration-denies-waiver-for-indianas-popular-medicaid-reform/>

In 2007, under Gov. Mitch Daniels (R.), Indiana enacted the Healthy Indiana Plan, an expansion of Medicaid that used consumer-driven health plans to encourage low-income beneficiaries to take a more active role in their own care. Today, Healthy Indiana is the most innovative and successful reform of Medicaid in the history of the program. Today, we learn that the Obama Administration has rejected the state's request to extend its federal waiver, which means that over 45,000 Indianans who get their insurance through the program are out of luck.

Medicaid, of course, is the nation's government-run health insurance program for the poor. In theory, it's jointly run by the federal government and the states, but in reality, any time a state wants to make the tiniest changes in its Medicaid program, it has to go hat-in-hand to the U.S. Department of Health and Human Services with a formal request for a waiver, and these waivers are usually denied.

Indiana succeeded in gaining a waiver in 2007 because it was seeking to expand Medicaid to a group of people who weren't then eligible for the program, and because the state's effort required no additional outlays from the federal government (the Medicaid expansion was paid for with a 44-cent increase in the state's cigarette tax.)

Structure of Indiana's consumer-driven Medicaid plan

Beneficiaries get a high-deductible health plan and a health savings account, called a POWER account, to which individuals must make a mandatory monthly contribution between 2 to 5 percent of income, up to \$92 per month. Participants lose their coverage if they don't make their contributions within 60 days of their due date. After making this contribution, beneficiaries have no other cost-sharing requirements (co-pays, deductibles, etc.) except for non-urgent use of emergency rooms. The state chips in \$1,100, which corresponds to the size of the would-be deductible.

Those who have money remaining in their POWER accounts at the end of the year can apply the balance to the following year's contribution requirements, if they have obtained a specified amount of preventive care: annual physical exams, pap smears and mammograms for women, cholesterol tests, flu shots, blood glucose screens, and tetanus-diphtheria screens.

"We did a lot of reading on criticism of health savings accounts," says Seema Verma, who was the architect of the Indiana program. "One of the criticisms was that people didn't have enough money to pay for preventive care. So we took preventive care out, made that first-dollar coverage. Also, people said that people didn't have enough for the deductible, so we fully funded it. Then, you have to make your contribution every month, with a 60-day grace period. If you don't make the contribution, you're out of the program for 12 months. It's a strong personal responsibility mechanism."

Indiana's Medicaid successes

The program has been, by many measures, a smashing success. "What we're finding out is that, first of all, low-income people are just as capable as anybody else of making wise decisions when it's their own money that they're spending," Mitch Daniels explains in a Heritage Foundation video. "And they're also acting more like good consumers. They're visiting emergency rooms less, they're using more generic drugs, they're asking for second opinions. And some real money is starting to accumulate in their [health savings] accounts."

The program has been overwhelmingly popular in Indiana. There's a large waiting list—in the tens of thousands—to enroll in Healthy Indiana; enrollment was capped in order to ensure that the program's costs remain predictable. 90 percent of enrollees are making their required monthly contributions. "The program's level of satisfaction is at an unheard-of 98 percent approval rating," Verma told Kenneth Artz. Employers didn't dump their workers onto the program, crowding others out, because you needed to be uninsured for six months in order to be eligible for it.

A 2010 study by Mathematica Policy Research found that the program dramatically increased the percentage of beneficiaries who obtained preventive care, from 39 percent in the first six months of enrollment to 59 percent after one year. Of the members who had money left in the POWER accounts at the end of the year, 71 percent met the preventive care requirement and were able to roll the balances over to the following year. (The remaining 29 percent could roll over their personal contributions, but not the state contributions to their POWER accounts.)

This is an astounding achievement, given that the biggest problem with Medicaid is the way that it ghettoizes its participants, preventing them from gaining access to routine medical and dental care. This lack of physician access is the biggest reason why health outcomes for Medicaid patients lag far behind those of individuals with private insurance, and even behind those with no insurance at all. Healthy Indiana has completely reversed this trend, achieving preventive care participation rates that are *higher* than the privately-insured population.

The program is not without blemishes. In 2009, the costs of the program exceeded the revenues gained from the cigarette tax, a problem that may continue in the current economic environment. But because enrollment is capped, the program can't cause the kinds of runaway fiscal problems that have roiled most states.

HHS declines to renew Indiana's waiver

Unfortunately for Indianans, the Healthy Indiana Plan's waiver expires at the end of 2012. And Kenneth Artz is reporting that the Obama Administration has denied Mitch Daniels' request for an extension. "We applied for an extension with the Department of Health and Human Services in March," Seema Verma told Artz. "They turned us down because they hadn't written the regulations for Obamacare yet." (H/T Ben Domenech.)

According to Verma, the state will now have to file a much more complex "State Plan Amendment" that may not get approved before the Healthy Indiana program is set to expire. Gov. Daniels has also written to HHS Secretary Kathleen Sebelius, asking her for permission to use the Healthy Indiana Plan to handle Obamacare's mandatory expansion of Medicaid. He hasn't heard back.

How can it be that the Obama Administration, which claims to side with the poor, is willing to destroy a popular program that provides the poor with superior health care? Perhaps it's a bureaucratic issue, as HHS told Verma. Perhaps it's an ideological suspicion of consumer-driven reforms. Whatever the reason, tens of thousands of people will be needlessly harmed, and it will be a black mark on those who are responsible.

Appendix 3

MICHAEL CANNON (Cato Institute), Testimony to the Interim Committee on Health Exchanges, Missouri Senate, September 15, 2011

http://www.cato.org/pub_display.php?pub_id=13692

Good morning, Chairman Rupp and members of the committee. I am very pleased to be with you today. My name is Michael F. Cannon. I am the director of health policy studies at the Cato Institute, a non-partisan, non-profit educational foundation in Washington, D.C.. The mission of the Cato Institute is to promote the principles of individual liberty, limited government, free markets, and peace.

Background

The most important health policy issue facing Missouri is the fate of the health care law that President Barack Obama signed last year, whose official title is the "Patient Protection and Affordable Care Act." That law is already increasing the cost of health insurance by as much as 30 percent in some cases, and will cause even greater premium increases in the years to come.

When that law takes full effect in 2014, it will set in motion several important changes. Though states are already struggling to pay for their current Medicaid programs, beginning in 2014, this law will add to those burdens with enormous unfunded mandates. The law imposes government price controls on health insurance that will dramatically increase premiums for healthy purchasers. The law's so-called "individual mandate" will increase premiums further and compel nearly all Americans to purchase a nominally private but government-designed health insurance policy. Those who fail to comply will face penalties including fines and/or imprisonment.

A study of the law's impact on Wisconsin by one of its leading proponents, MIT economist Jonathan Gruber, projects that due to the law's government price controls and individual mandate alone, "87 percent of the individual market will experience an average premium increase of 41 percent." Though the law creates a new entitlement to premium assistance for qualified

individuals, Gruber found that even after accounting for that new entitlement spending, "59 percent of the individual market will experience an average premium increase of 31 percent."

Finally, the law envisions health insurance "Exchanges" that would become operational in 2014. These new government bureaucracies would enforce these costly new regulations and distribute hundreds of billions of taxpayer dollars to private health insurance companies, thereby driving up the national debt. The law allows but does not require states to create an Exchange. To be clear: Missouri is under no obligation to create a health insurance Exchange. The authors of the health care law knew that such a requirement would be unconstitutional. Instead, the law asks states to do the heavy lifting of creating these bureaucracies, and as a fallback allows the federal government to create an Exchange if a state declines to do so.

The Health Care Law's Future Is in Doubt

Supporters introduced the first draft of President Obama's health care law in Congress in June 2009, and a bipartisan majority or plurality of the American people have consistently opposed it ever since. A mere 38 percent of the public supports the law. Opposition is highest among likely voters. More than 80 percent of Americans oppose the law's individual mandate; Missouri voters overwhelmingly supported a referendum to block it. Officials representing 28 states (including Missouri) and both political parties have filed suit to overturn the entire law. Multiple federal courts have struck down all or part of the law as unconstitutional. Legal experts predict the U.S. Supreme Court will ultimately rule on the law's constitutionality sometime in the summer of 2012. One of the two major political parties has committed itself to wholesale repeal.

Should Missouri Create a Health Insurance Exchange?

Against this backdrop, the most immediate question facing state officials is whether to create a health insurance Exchange. In the remainder of my remarks, I will explain why, whether one opposes or supports this law, the responsible course is not to create an Exchange.

The question of whether or not to create an Exchange is simplest for state officials who have taken the position that the federal health care law is unconstitutional. Missouri officials, like state officials nationwide, take an oath to protect not just their own state's Constitution, but also the Constitution of the United States. They are therefore oath-bound to use all lawful means to block a law that they believe violates the U.S. Constitution. The same duty that obliges those officials to sue to overturn the health care law also obliges them not to implement it. To implement this health care law, to create an Exchange, is to violate their oath of office.

Whether you support or oppose the law, there are several reasons for Missouri legislators not to create an Exchange.

First, you don't have the time. There is not just one Exchange; there are two of them. If you opt to create an Exchange, then among your many responsibilities will be such diverse tasks as the following. You would be responsible for ensuring that carriers do not follow the law's enormous financial incentives to avoid, mistreat, and dump the sick. You would have to run a reinsurance program and a risk-adjustment program. You would have to define and monitor "network adequacy" as well as each insurance carrier's service area. You would have to monitor each carrier's marketing materials. You would have to monitor and enforce carriers' compliance with the law's other anti-discrimination provisions. You would have to fund and monitor the "navigators" the law envisions. You would have to fund the Exchange in 2015 and beyond, perhaps with a premium tax. (Oregon has opted for a premium tax of up to 5 percent.) Then

there's all the reporting you would have to do to Washington, the approvals you would have to obtain, and the months and months of waiting for an answer on everything.

Unless Missouri's economy and unemployment situation are somehow bucking the national trend, Missouri's elected officials have more pressing matters to attend. If you do somehow find that you are not busy enough, at the end of my testimony I suggest some real health care reforms you might advance.

Second, you don't have the money. Because, there is no money. Unless Missouri's state budget is likewise bucking the national trend, neither Missouri nor the federal government has money to spend on new government bureaucracies. Every dollar that Missouri spends on an Exchange is a dollar it cannot spend on roads, education, or police — or more important, a missed opportunity to spur economic recovery by reducing the tax burden. Any federal grants that Missouri has already received, and any additional federal funds it may receive, are adding to the nation's debt burden and bringing the United States closer to a Greek-style debt crisis. The fiscally responsible option, which many states have exercised, is to send that money back to Washington and to refuse any additional funds.

Third, it makes little sense to create a new government bureaucracy today to implement a law that may be repealed or overturned tomorrow.

Fourth, creating an Exchange will leave Missouri officials to take the blame when this law begins hurting the state's sickest patients.

When the Exchanges open for business, they will be inundated with high-cost patients. The government price controls that the law imposes on health insurance premiums will create massive incentives for insurers to avoid, dump, and mistreat the sick — as carriers have done in every market where governments have imposed these price controls.

The law creates several programs whose sole purpose is to protect sick people from the perverse incentives inherent in these price controls. I mention many of these programs above: programs that tax some health plans in order to subsidize others, "network adequacy" rules, requirements that carriers serve a large enough "service area," restrictions on marketing, and other anti-discrimination provisions.

States that create their own Exchanges will be responsible for running these programs and protecting the sick from the rest of the law. Let's be clear about what is happening here: the federal government is offering insurers huge financial rewards if they mistreat the sick, and it wants you to stop insurers from chasing those rewards. The problem is, you can't. Those programs will inevitably fail, and many of Missouri's sickest patients will be hurt and angry. Those patients will blame whoever was supposed to stop the insurers from misbehaving. If Missouri creates an Exchange, those patients will blame you for not standing up to the insurance companies like they should have, and you will be treated to political attack ads where very sick patients tell your constituents how you don't care about them. If you create an Exchange, you are volunteering to take a bullet for the federal government, and shield federal officials from responsibility for their actions.

Some Exchange proponents argue that creating an Exchange will give Missouri officials more control over Missouri's health insurance market. Paradoxically, it would give them less control because it would cement in place the federal government's takeover of Missouri's market.

The promise of local control is a mirage. The law allows the federal government to commandeer any state-run Exchange that falls short of full compliance with federal dictates. An Obama administration missive explains that the new law "authorizes [the federal government] to ensure that States with Exchanges are substantially enforcing the Federal standards ... and to set up Exchanges in States that elect not to do so *or are not substantially enforcing related provisions.*" (Emphasis added.)

The fact that an Exchange is state-run does not diminish federal control by one iota. There is nothing that a federal Exchange can do that the federal government cannot also force a state-run Exchange to do through regulation. The federal government will heap regulations upon state-run Exchanges; indeed, it is already imposing greater requirements on them than the law itself does. Creating a state-run Exchange would not prevent a federal takeover of Missouri's health insurance markets; it would lend manpower to that effort.

Some opponents of the law nevertheless argue for creating an Exchange so that states can be prepared in case the law is not overturned or repealed. Yet creating an Exchange would entrench the law and make it less likely to be repealed or overturned.

- First, creating an Exchange lends a veneer of legitimacy to the law. The Obama administration heralds the creation of each new Exchange as proof that the law is gaining acceptance, and heralds states accepting the federal grants available under the law in the same manner.
- Second, declaring the law unconstitutional but then accepting the funding it offers and creating an Exchange undermines the credibility of state officials seeking to overturn the law and also undermines the lawsuits themselves. One federal judge who overturned the law wrote that the fact that some of the plaintiff states are themselves implementing the law undercut their own argument that he should order the federal government to halt implementation.
- Third, to create an Exchange is to create a taxpayer-funded lobbying group dedicated to fighting repeal. An Exchange's employees would owe their power and their paychecks to this law. Naturally, they would aid the fight to preserve the law.
- Fourth, both Congress and the courts are less likely to eliminate actual government bureaucracies that have assembled dedicated constituencies than they are to eliminate theoretical ones. The more disruptive repeal would be, the less likely it becomes.
- Fifth, many knowledgeable observers believe few Exchanges, state or federal, will be operational by 2014. If states like Missouri create their own Exchanges, they will begin handing out billions of taxpayer dollars sooner than if the federal government creates them. Creating a state-run Exchange will hasten the day when the private insurance companies who receive those subsidies plow much of the money back into fighting repeal.
- Sixth, and perhaps most important, due to a recently discovered glitch in the statute, the new health care law only authorizes premium assistance in state-run Exchanges — not federal Exchanges. States thus have the collective power to deny the Obama administration the legal authority to dispense more than a half-trillion dollars in new entitlement spending, to expose the full cost of the law's mandates and government price controls, as well as to enforce the law's employer mandate — simply by not creating Exchanges. If Missouri joins other states in refusing to create an Exchange, it can

essentially force Congress to reconsider the law. If Missouri instead creates an Exchange, it will increase the federal deficit and debt, hide the full cost of the health care law, expose Missouri employers to penalties and reduce the likelihood of repeal.

The Obama administration is offering financial inducements to states to create Exchanges because the administration knows that every new Exchange helps them shield the law from Congress, the courts, and the American people. Creating an Exchange is not a hedging-your-bets strategy but a sabotaging-your bets strategy.

Some conservatives have recommended that states create "market-friendly" (i.e., non-compliant) Exchanges that offer an "alternative vision" to the law. There is no conservative rationale for doing so. Former Utah Gov. Jon Huntsman (R) created a health insurance Exchange in 2008. A Utah official overseeing that Exchange says, "Nearly every Exchange function already exists in the private sector." EHealthInsurance.com already enables one-stop shopping for health insurance. One conservative group advocates government-created Exchanges because its analysts see Exchanges as a vehicle for enabling workers to purchase their own health plan using tax-free dollars from their employers. Workers can already do that under a provision of the federal tax code known as "health reimbursement arrangements," or HRAs. Companies like Minneapolis' Bloom Health are helping employers take advantage of HRAs and giving workers that freedom, without any new government bureaucracies or regulations.

Fundamentally, there is no such thing as a market-friendly government bureaucracy. As Thomas Jefferson explained more than 200 years ago: "The natural progress of things is for liberty to yield, and government to gain ground." Government bureaucracies will always seek more control because that is their nature. Former Massachusetts Gov. Mitt Romney (R) proposed a "market-friendly" health insurance Exchange in 2006. By the time he signed it into law, it had become the very market-unfriendly plan on which Congress modeled the federal law. When Utah politicians saw that health insurance was more expensive inside their Exchange than on the open market, they imposed a series of taxes on consumers outside of the Exchange to prop up the health plans inside it. In the process, Utah unwittingly put in place the infrastructure for a federal Exchange: if Utah's Exchange fails to comply with the health care law in 2014, the federal government will commandeer it or brush it aside.

Whatever is plaguing America's health care sector, a lack of government bureaucracies is not it. There is simply no reason for Missouri to create any kind of Exchange.

Finally, I encourage you to bear in mind that the interests of those asking the legislature to create an Exchange may not line up with the interests of patients. For instance, private insurers' pro-Exchange lobbying efforts may be related to the fact that Exchanges are necessary for them to tap hundreds of billions of dollars in taxpayer subsidies. Similarly, insurance regulators and state health care officials across the country have urged their governors and legislatures to create an Exchange, otherwise they would have to watch the federal takeover from the sidelines rather than be an active participant. Of course, a state-run Exchange cannot preserve their influence. Only repealing or overturning the health care law can do that.

Conclusion

The most responsible course for Missouri is to refuse to create an Exchange. Many governors, including Florida's Rick Scott (R) and Louisiana's Bobby Jindal (R) have already done so. Missouri should also send back to Washington whatever funds it has received under this law, as Kansas, Oklahoma, Wisconsin, Florida, and other states have done. Missouri can send that

money back with a message that if Congress is looking to cut federal spending, a good place to start would be laws that federal courts have declared unconstitutional.

In the meantime, there are other steps Missouri can take to make health insurance and medical care more affordable to consumers.

First, the General Assembly can permit Missouri employers and consumers to purchase health insurance licensed by other states. Wyoming, Maine, and Georgia have already given their residents this freedom. Enabling Missouri residents to purchase health insurance across state lines would expand choice and competition, and would reduce premiums by letting consumers avoid unwanted regulatory costs. As important, granting Missouri residents this freedom would not require any new government spending or the creation of any new government bureaucracies. Domestic carriers typically object to giving consumers this freedom because they would prefer what they call a "level playing field" — i.e., where government protects them from competition, and leaves Missouri residents with fewer choices.

Second, the General Assembly can make basic medical care more affordable for the poor by broadening the scopes of practice of mid-level clinicians such as nurse practitioners and physician assistants. One promising approach, similar to letting Missouri residents purchase health insurance across state lines, is to let clinicians licensed by other states practice in Missouri under the terms of their license but subject to Missouri's malpractice laws. Reforms such as these would spur the growth of retail clinics and other innovations that bring quality medical care within reach for more low-income Missouri residents. At a minimum, Missouri should emulate Tennessee by allowing clinicians licensed by other states to provide free charitable care to Missouri residents under the terms of their license.

Third, the General Assembly can reduce unnecessary medical malpractice costs by giving patients and doctors the freedom to choose higher or lower caps on non-economic damages than Missouri currently mandates. The obstacle to patients and providers (and insurers) exercising this freedom is that courts will not enforce such contracts. Thus we have a perverse situation where judges can by fiat force patients to "purchase" an unlimited right to sue, or the legislature can by fiat drastically reduce their right to recover, but the patient has no power to voice her preference for higher or lower caps. The General Assembly should instruct Missouri judges to enforce contracts that adopt alternative caps and other medical malpractice reforms. This approach would make lower caps available to those who want them, but still allow others to enjoy broader malpractice protections.

Fourth, Missouri should apply for a waiver from the health care law's Medicaid expansion that would allow the state to replicate the Oregon Health Insurance Experiment on a larger scale. Instead of expanding Medicaid to all residents below 138 percent of the federal poverty level as the new law requires, which one study projects would add 300,000 new recipients to Missouri's Medicaid rolls by 2019, the state could randomly assign half of this group to receive Medicaid coverage and the other half not to receive it (much like Oregon did in 2008), and then measure the outcomes of both groups. Such a study could help fill the tremendous gaps in our knowledge about the actual benefits of expanding Medicaid, and whether there are more cost-effective ways of improving the health of low-income households. Along the way, such a waiver would reduce both state and federal spending.

Again, I am very pleased to be with you today, and I look forward to any questions you may have.

Appendix 4

Goldwater Institute Policy Memo

November 4, 2011

<http://goldwaterinstitute.org/article/6398>

To: Governor Brewer, Legislators, Policymakers
From: Diane Cohen, Senior Attorney, Goldwater Institute
RE: Ten Reasons Why Arizona Must Reject Health Insurance Exchanges

“The key provision of the Affordable Care Act is the implementation of State-run Health Insurance Exchanges.”

The above quote comes not from the Obama Administration, but from Arizona Governor Jan Brewer.¹ In furtherance of this “key provision,” the governor has created the Governor’s Office of Health Insurance Exchange, with a projected budget of more than \$29.5 million over the next 32 months. In recognizing that exchanges are “key” to implementation of the “Affordable Care Act,”² the governor’s office is in lockstep with both the Obama Administration, which argued in its legal briefs defending the law that the establishment of exchanges was critical to enforcing the individual mandate,³ and the New York Times, which wrote that the “success of President Obama’s health care overhaul . . . depends on the creation of . . . health insurance exchanges.”⁴ Worse still, the governor’s office is exploring ways to establish an exchange via executive order,⁵ in an attempt to circumvent the legislature, which has opposed a state exchange.

Thus, the legislature may find itself on the front line in protecting Arizona from this unconstitutional law and the state’s interests in the 26-state lawsuit challenging Obamacare, which is currently on its way to the U.S. Supreme Court. The legislature may also be needed to preserve Arizona’s Health Care Freedom Act (HCFA) by stopping Arizona from becoming complicit in Obamacare.

Whether state or federally established, exchanges are government-sanctioned cartels where only government- approved insurers can sell only government-approved insurance. While proponents claim that states should establish an exchange in order to fend off a federally established one and preserve state control, a review of the law and proposed regulations reveal that establishing an exchange will accomplish none of these objectives. Following are select provisions of the law and the proposed regulations that show the extent of federal control over the exchanges. These provisions show that states will not be able to maintain any meaningful control or “flexibility” by establishing an exchange. Likewise, they show that any state that establishes an exchange will be enforcing the individual mandate.

Ten Reasons Why Arizona Must Reject Exchanges

1. The federal government controls exchanges. “An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary [of

Health and Human Services (HHS)].”⁶ Further, the Secretary and the General Accounting Office will have continuing oversight over exchanges.⁷

2. The federal government controls the doctors and other providers that are allowed to participate in an exchange-offered plan. The Act mandates that only providers who “implement[] such mechanisms to improve health care quality as the Secretary may by regulation require” may participate in a “qualified plan” offered on the exchange.⁸
3. The federal government controls health insurance plans and benefits. The Act prescribes the minimum essential benefits that must be included in a plan and gives authority to the HHS Secretary to prescribe more.⁹ HHS is also required to establish the criteria for the certification of health plans as “qualified.”¹⁰ As a result, only HHS-approved plans may be sold in the exchange.¹¹
4. While federal mandates remain, federal funds cease at the end of 2014. Both PPACA and the proposed regulations prohibit federal funds for state exchanges after January 1, 2015. No federal grants will be awarded after January 1, 2015.¹² States must ensure that the exchanges are self-sustaining by January 1, 2015, and must find other sources of funding, through “assessments and user fees,” “provider taxes,” “State revenues,” or other sources¹³
5. Arizona will surrender its 10th amendment sovereignty by establishing an exchange. The HHS proposed regulations themselves acknowledge that a state’s submission to an exchange has an adverse impact on federalism principles. In compliance with Presidential Executive Order 13132,¹⁴ which requires agencies to assess whether their rules will affect federalism, HHS reported that the proposed exchange regulations have “Federalism implications due to the direct effects on the distribution of power and responsibilities among the State and Federal governments.” However, HHS determined that the federalism implications are “substantially mitigated” because PPACA “does not require States to certify an Exchange.”¹⁵ Therefore, when a state chooses to establish an exchange, it voluntarily surrenders its sovereignty.
6. The state must enforce the individual mandate and penalty. State exchanges are responsible for determining whether an individual is exempt from the individual mandate and for granting certification for those who are exempt. The exchange must also “support and complement rulemaking conducted by the Secretary of the Treasury” with respect to the law.¹⁶
7. The state must turn over names of individuals who do not comply with the individual mandate. Obamacare requires the exchange to give to the U.S. Treasury the names and taxpayer identification numbers of individuals who have changed employers and ceased coverage under a qualified health plan during a plan year.¹⁷ The same would be true for an individual unsuccessfully seeking an exemption from the mandate via the exchange or otherwise subjecting himself to the exchange, but then choosing not to purchase insurance.

8. The state must report citizen information to the federal government. Exchanges must record and report to HHS on a monthly basis all individuals who terminate their enrollment in insurance obtained through the exchange.¹⁸
9. So-called state “flexibility” is belied by the law. Despite a provision in the Act titled “State Flexibility in Operation and Enforcement of Exchanges and Related Requirements,” the law in fact confers no flexibility to the states, only more authority to the HHS Secretary over the state exchanges. For example, the Act provides that states can establish exchanges, but only as “prescribe[d]” by the HHS Secretary.¹⁹ The Act also allows states to adopt exchange laws and regulations, but only those that “the Secretary determines implements the standards within the State.”²⁰ Moreover, this provision states that “[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title,” which is just another way of saying that a state law is only valid if it does not conflict with federal law and regulation.²¹
10. States are only as flexible as federal law permits them to be.²² Yes, states can choose whether the exchange will be run by a state agency or a non-profit established by the state, but both are subject to federal approval, regulation, and perpetual oversight.²³ According the Governor’s Office, an Arizona exchange would be established either in her office or as a separate state agency, but Arizona will not create a non-profit agency to run the exchange.²⁴

States also have so-called “flexibility” to decide whether to open exchanges to all insurers, or to limit the number and participation to only those plans that meet unspecified “exchange criteria.”²⁵ But all this “flexibility” essentially allows is the creation of a state and federally-controlled market where the state determines which insurers participate and which plans and coverage are available. If Arizona exercised such authority to limit the plans, coverage options and companies allowed to participate in the exchange, it would violate the HCFA provision in the state constitution, which protects the right of Arizona citizens to buy (or not buy) insurance plans of their choice that best suit their needs.

Conclusion

As exemplified through Arizona’s enactment of the Health Care Freedom Act and Save Our Secret Ballot, Arizona is a leader in defending state sovereignty and individual liberty. Arizona is also a plaintiff in the victorious Florida Obamacare lawsuit, which the Supreme Court will soon consider. While the District Court found Obamacare unconstitutional, it allowed the government to implement the law pending appeal, specifically noting that several of the prevailing states continued to carry out its provisions, including accepting exchange grant money. Arizona should not put this important legal victory in jeopardy by entrenching this unconstitutional law before the Supreme Court decides the case.